FH

STATE OF WISCONSIN
Division of Hearings and Appeals

In the Matter of

[redacted]

DECISION

HMO/152517

PRELIMINARY RECITALS

Pursuant to a petition filed September 27, 2013, under Wis. Stat. § 49.45(5)(a), and Wis. Admin. Code § HA 3.03, to review a decision by the Division of Health Care Access and Accountability in regard to Medical Assistance, a hearing was held on October 22, 2013, at Kenosha, Wisconsin.

The issue for determination is whether Community Connect correctly denied Petitioner's request for services from an out-of-network provider.

There appeared at that time and place the following persons:

PARTIES IN INTEREST:
Petitioner:

[redacted]

Respondent:

Department of Health Services
1 West Wilson Street, Room 651
Madison, Wisconsin 53703
By: Tina Mason, MD of Community Connect Health Carte on behalf of
Department of Health Services
Division of Health Care Access And Accountability
Madison, WI

ADMINISTRATIVE LAW JUDGE:
David D. Fleming
Division of Hearings and Appeals

FINDINGS OF FACT

1. Petitioner is a resident of Kenosha County.

2. This appeal was filed by or on behalf of Petitioner seeking an order from the Division of Hearings and Appeals permitting Petitioner to have surgery by an out of network provider.

3. Petitioner had bilateral breast reduction surgery on July 3, 2012. She seeks a second bilateral reduction. She would like to have the same physician perform this second surgery but that physician is no longer in practicing in Wisconsin or in practice with Petitioner's HMO Community Connect Health Plan. That physician stated in an August 16, 2013 letter that that Petitioner healed satisfactorily from the July 2012 surgery and that her post-operative course was uneventful. He did request that that: "In the interest of continuity of care, please allow her to see me and work with me at the Libertyville Illinois location." See Attachment 5 to Exhibit # B.

4. This matter was reviewed by the Department of Health Services and it confirmed that the denial was correct.

DISCUSSION

Under the discretion allowed by *Wis. Stat., §49.45(9)*, the Department of Health Services (DHS) requires MA recipients to participate in HMOs. *Wis. Admin. Code, § DHS 104.05(2)(a).* Medicaid recipients enrolled in HMOs must receive medical services from the HMOs' providers, except for referrals or emergencies. *Wis. Admin. Code, § DHS 104.05(3).* Providers are reimbursed for medically necessary and appropriate health care services. *Wis. Admin. Code, § DHS 107.01.*

"Medically necessary" means a medical assistance service under ch. DHS 107 that is:

> (a) Required to prevent, identify or treat a recipient's illness, injury or disability; and
> (b) Meets the following standards:
> 1. Is consistent with the recipient's symptoms or with prevention, diagnosis or treatment of the recipient's illness, injury or disability;
> 2. Is provided consistent with standards of acceptable quality of care applicable to the type of service, the type of provider, and the setting in which the service is provided;
> 3. Is appropriate with regard to generally accepted standards of medical practice;
> 4. Is not medically contraindicated with regard to the recipient's diagnoses, the recipient's symptoms or other medically necessary services being provided to the recipient;
> 5. Is of proven medical value or usefulness and, consistent with s. DHS 107.035, is not experimental in nature;
> 6. Is not duplicative with respect to other services being provided to the recipient;
> 7. Is not solely for the convenience of the recipient, the recipient's family, or a provider;
> 8. With respect to prior authorization of a service and to other prospective coverage determinations made by the department, is cost-effective compared to an alternative medically necessary service which is reasonably accessible to the recipient; and
> 9. Is the most appropriate supply or level of service that can safely and effectively be provided to the recipient.
> *Wis. Admin. Code, §DHS 101.03(96m).*

I note at this point that a petitioner has the burden of proving that the requested item meets the approval criteria and that the standard level of proof applicable is a "preponderance of the evidence". This legal standard of review means, simply, that "it is more likely than not" that a petitioner and/or his/her representatives have demonstrated that the requested item meets the criteria necessary for payment by the Wisconsin Medicaid program. It is the lowest legal standard in use in courts or tribunals.

Wisconsin law mandates the following. *Wis. Admin. Code §DHS 107.27(3)(a)*, states that HMOs must, "Allow each enrolled recipient to choose a health professional in the organization to the extent possible and appropriate." *Emphasis added Wis. Admin. Code §DHS 104.05(3)* also states that, "enrollees in an HMO or PHP shall obtain services paid for by MA from that organization's providers, except for referrals

or emergencies. Recipients who obtain services in violation of this section shall pay for these services." Further, the *Wis. Admin. Code §DHS 104.03* states that, "free choice of a provider may be limited by the department if the department contracts for alternate service arrangements which are economical for the MA program and are within state and federal law, and if the recipient is assured of reasonable access to health care of adequate quality." *See also Wis. Stats. §49.45(9).* Thus, a Medicaid recipient's choice of doctors may be limited as long as the recipient will receive adequate health care.

Petitioner was represented at the hearing by her mother. Her testimony was that it is best to have a second breast reduction performed by the original physician as there are nuances to the technique and procedure that make it difficult for a second physician to perform this particular 2nd surgery. She argues that continuity of care requires that the original surgeon be allowed to perform the second surgery.

The HMO involved here, Community Connect Health Plan, denied Petitioner's request that physician who had performed the 2012 breast reduction be permitted to perform this second breast reduction. Community Connect Health Plan indicated in its denial that an out-of-network provider is not a covered benefit and that there are participating network providers within a 50 mile radius. The Wisconsin Department of Health Services reviewed this case and confirmed the Community Connect denial. The Department did not find that this was a continuity of care issue.

While there is not a good definition of continuity of care in the record I do note that Petitioner apparently healed well and without complications from the 2012 surgery. Further, what is really missing here is documentation that Petitioner has sought treatment from Community Connect providers and that they will not perform the requested surgery and that it must be performed by the original physician. While it may be ideal that the original physician perform the surgery that does not mean it is medically necessary.

Please note that the requested surgery may be subject to prior authorization requirements even if it were to be performed by a Community Connect provider.

CONCLUSIONS OF LAW

That Community Connect correctly denied Petitioner's request for services from an out-of-network provider.

THEREFORE, it is **ORDERED**

That this appeal is dismissed.

REQUEST FOR A REHEARING

This is a final administrative decision. If you think this decision is based on a serious mistake in the facts or the law, you may request a rehearing. You may also ask for a rehearing if you have found new evidence which would change the decision. Your request must explain what mistake the Administrative Law Judge made and why it is important or you must describe your new evidence and tell why you did not have it at your first hearing. If you do not explain these things, your request will have to be denied.

To ask for a rehearing, send a written request to the Division of Hearings and Appeals, P.O. Box 7875, Madison, WI 53707-7875. Send a copy of your request to the other people named in this decision as "PARTIES IN INTEREST." Your request for a rehearing must be received no later than 20 days after the date of the decision. Late requests cannot be granted.

The process for asking for a rehearing is in Wis. Stat. § 227.49. A copy of the statutes can be found at your local library or courthouse.

APPEAL TO COURT

You may also appeal this decision to Circuit Court in the county where you live. Appeals must be served and filed with the appropriate court no more than 30 days after the date of this hearing decision (or 30 days after a denial of rehearing, if you ask for one).

For purposes of appeal to circuit court, the Respondent in this matter is the Department of Health Services. After filing the appeal with the appropriate court, it must be served on the Secretary of that Department, either personally or by certified mail. The address of the Department is: 1 West Wilson Street, Room 651, Madison, Wisconsin 53703. A copy should also be sent to the Division of Hearings and Appeals, 5005 University Avenue, Suite 201, Madison, WI 53705-5400.

The appeal must also be served on the other "PARTIES IN INTEREST" named in this decision. The process for appeals to the Circuit Court is in Wis. Stat. §§ 227.52 and 227.53.

Given under my hand at the City of Milwaukee,
Wisconsin, this 20th day of December, 2013

\sDavid D. Fleming
Administrative Law Judge
Division of Hearings and Appeals

State of Wisconsin\DIVISION OF HEARINGS AND APPEALS

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The preceding decision was sent to the following parties on December 20, 2013.

Division of Health Care Access And Accountability